Report for:	Joint Health and Wellbeing Board Sub Committee
Date:	9 October 2017
Title:	Update on the Wellbeing Partnership
Report authorised by:	Sean McLaughlin, Chair of the Wellbeing Partnership
Lead Officer:	Rachel Lissauer, Director of the Wellbeing Partnership

1. Purpose

1.1 The Wellbeing Partnership has been established to support and drive improvement in health and wellbeing for our populations. The Partnership arose from our shared desire to focus on improving outcomes and a recognition of the inter-dependency between the organisations providing and commissioning health and care. The Wellbeing Partnership provides an infrastructure to make strategic decisions across organisations; to better support integration of care on the ground and to take a collective approach towards our all-important workforce, estates and IT infrastructure. It seeks to take opportunities to scale up good practice and reduce duplication between our organisations and boroughs. By working together, we want to develop incentives that promote improvement in outcomes and to target financial resources within our health and care economy where they will maximise health improvement and ensure future sustainability of health and care.

1.2 This paper provides an update for the Joint Health and Wellbeing Board on progress with the Wellbeing Partnership since the last meeting.

1.3 Key messages for the Board are that:

- The Wellbeing Partnership is making good progress and is recognised as an early adopter within the NCL STP. We are developing in line with national ambitions and policy in relation to accountable care partnerships / systems.
- Local leadership is key to our ability to continue to work at pace on developing our accountable care system.
- Organisations are, through the Sponsor Board, starting to share information about investment and spending decisions such as the Better Care Fund and primary care investment.
- We have started to work through the implications of using the partnership to drive service improvement where we might otherwise have relied on a competitive procurement process to achieve service change.
- The governance structure has been re-shaped in order to use the Wellbeing governance to streamline decision-making.
- Work-streams are progressing and are having a demonstrable and positive impact on care. Examples are set out in the paper.

- A substantive Director has been appointed to lead the Wellbeing Partnership and is recruiting a programme team. Sean McLaughlin has taken on the role of Chair of the Wellbeing Sponsor Board.

1.4 The next phase of work will involve:

- Participating within a network of developing Accountable Care Systems either at London or North Central London level to benefit from the learning from Vanguards and other sites.
- Recruitment to the Wellbeing Partnership team to build our delivery capacity
- Establishing how best the Wellbeing Partnership can best support Care Closer to Home Integrated Networks (CHINs) and Quality Improvement Support Teams (QISTs).
- Development of an engagement strategy
- Increased focus on workforce and estates as enablers of system change with more dedicated project support

2. Issue under consideration

2.1 This update is an opportunity for the Joint Sub-Committee to review progress that has been made against the ambitions set out within the Partnership Agreement and to influence the pace and direction of the next phase of work.

3. Recommendation

3.1 The Joint Sub-Committee is asked to NOTE the developments set out within the paper.

4. Background

4.1 In June the committee noted that a Partnership Agreement had been approved at Board level by Islington Council and CCG; Haringey Council and CCG; Whittington Health; UCLH and the Islington and Haringey GP Federations (as organisations and not on behalf of individual member practices). It is important to note that organisations that have not signed the Partnership Agreement have continued to participate in the Wellbeing Partnership at both operational and executive level.

4.2 In June the Sponsor Board met for an informal away-day. This session was a stock-take, in light of the Partnership Agreement and the strategic direction presented by the STP. Leaders at the meeting committed to an increased delivery-focus from the Wellbeing Partnership and on the need for engagement with staff. The group reflected on the need for strong clinical and professional input into the programme of work. It agreed that primary care; community services and intermediate care (step down / step up from hospital) were core areas for joint work and that the emergent Care Closer to Home Integrated Networks (CHINs) and Quality Improvement Support Teams

(QISTs) should be overseen and steered through the Wellbeing Partnership to ensure a genuinely system-led approach.

4.3 One of the key themes was the need to clearly articulate what benefits for our population are being achieved through our work as a system or partnership.

4.4 The Wellbeing Partnership is not a separate entity but is the enabling structure that we are putting in place to allow us to make progress more quickly and with greatest impact on outcomes and sustainability. The section below highlights examples of work that has been led from within the Wellbeing Partnership because of its importance for managing 'rising risk' and supporting improved health outcomes and sustainability of health and care services. This work is being delivered by clinicians and managers as part of their 'day job' but would previously have been carried out on a single borough footprint and not necessarily with the same level of collaboration between commissioners and providers. In all cases, joint working has facilitated spread and a consistency of approach.

5.1 Case studies of impact of working together within the Wellbeing Partnership

5.2 Intermediate Care

Intermediate care is about providing residents with effective short-term rehabilitation and re-ablement to maintain independence, prevent hospital and care home admission and support hospital discharge. Haringey and Islington have committed to work together on simplifying the discharge process, ensuring that people waiting to leave hospital have assessments in their own home environment wherever possible rather than waiting in hospital for assessments of care needs to be undertaken. We had also agreed to align our rapid response admission avoidance services and, in the long term, to jointly plan how our intermediate care beds are used.

5.3 Since the last update to the Joint Sub-Committee we have continued running this improved discharge process (or 'discharge to assess') for Haringey patients from NMH. This has released approximately 358 bed days over 35 weeks and streamlined the discharge process for 127 people. Commissioners and providers have now initiated improved hospital discharge pathways (discharge to assess) at the Whittington Hospital for both Haringey and Islington residents and at UCLH for Islington patients. The initial pilot of 10 discharge to assess patients has been completed. This is now being scaled up to become 'business as usual' with the aim of supporting three patients per week by the 25th September (a combined figure across both UCLH and Whittington Health). Islington has secured funding to support discharge to assess for patients with more complex needs. An operational model for this is being developed and recruitment processes are under way with a view to starting implementation in October.

5.4 The Boroughs have carried out an audit of our intermediate care beds, to make sure we have the right mix of intermediate care bed provision and that our beds have the right support to help residents re-gain their independence.

5.5 Cardiovascular disease and diabetes

5.6 In both Haringey and Islington there are significant issues in cardio-vascular disease (CVD) and diabetes care relating to health and wellbeing outcomes, quality of care provision, value for money of care provision and the current model of care delivery. Cardiovascular disease is a leading cause of death in both Haringey and Islington. For example, Islington is 118th worst and Haringey 147th worst out of 147 areas for premature mortality from stroke. Mortality from cardiovascular disease is closely linked to deprivation. We have large numbers of people (over 50,000) in our boroughs with undiagnosed hypertension and that primary care management of diabetes and CVD is highly variable and often below the London average. This is therefore a key area for us to focus on for long term health improvement and stabilising demand for health and social care in the long term.

5.7 In June we reported that the public health teams had successfully bid for funding from a British Heart Foundation Grant to carry out 5,000 blood pressure checks. Over 70 staff and volunteers from a range of voluntary organisations have now received training on performing blood pressure checks and the first blood pressure checks will be being carried out by early October.

5.8 For diabetes, both Haringey and Islington are developing plans to improve achievement of the 3 key treatment areas (blood pressure, blood sugar control and cholesterol) across our populations, which will reduce the risk of complications like stroke, kidney disease and blindness. Both Boroughs have received transformation funding to support the delivery of these treatment targets. This year Haringey will, for the first time, be supporting GPs to implement a locally commissioned service for improving the management of diabetes and cardiovascular disease.

9. Musculoskeletal care

9.1 Musculosketal (MSK) conditions include over 200 different conditions affecting joints, bones, muscles and soft tissues. MSK covers individual services like orthopaedics, rheumatology, chronic pain and physiotherapy. As well as back and neck pain, MSK services also deal with shoulder, elbow, wrist, knee, ankle and foot problems**.** MSK disorders account for the largest proportion of years lived with disability.

9.2 At the moment many patients – who might actually receive care more appropriately from physiotherapists – are being referred to pain management clinics; orthopaedic specialists and rheumatologists. But waiting times for

physiotherapy are very high and the referral routes at the moment are very complex, creating confusion and waste for both staff and patients. A new clinical pathway has been developed with high levels of clinical engagement. This will involve a 'single point of accesses to an enhanced physiotherapy triage service.

9.3 The joint commissioner and provider programme team is now working up an operational plan to establish a pilot of clinical triage of MSK referrals. In order to scope and resource full scale implementation, we are also carrying out audits of current referrals to assess feasibility of the plan for enhanced triage and to establish the likely scale of shift in activity from secondary care, and capacity required in community physiotherapy / pain services.

9.4 Progress in relation to the aims set out in the Partnership Agreement

9.5 Whilst workstreams are progressing, the Partnership Agreement set out a further set of ambitions for how we wanted to work together as a system. This section sets out the work that is being taken forward in relation to the commitments made in the Partnership Agreement and identifies the areas for focus in our next phase of work.

9.6 Joint Health and Wellbeing Strategy and greater alignment between public health teams

9.7 The Partnership Agreement set out the intention for the public health teams to work collaboratively and to develop a Joint Strategic Needs Assessment (presented to today's HWB) and single Health and Wellbeing Strategy for the two boroughs.

9.8 Public health leadership teams are working together on thematic areas in common, including diabetes and a BHF bid for stroke.

9.9 In the next phase the teams will be reviewing services and budgets between both boroughs to provide a deeper understanding of the services commissioned and supported by both Public Health teams.

9.10 Joint focus on transformation; bringing together service improvement projects and establishing single management leads for projects wherever possible

9.11 In the formation of the Partnership Agreement it was noted that organisations have separate transformation teams, with potential scope for greater alignment and joint working.

9.12 Joint service improvement work is now being undertaken across Haringey and Islington in a variety of areas. Councils have also identified opportunities for working together at a North Central London level and this joint work will support the aims of the Wellbeing Partnership.

9.13 The Partnership Agreement set out an ambition to let operational leads have authority across different organisations where appropriate. This would mean, for example, a single person having management responsibility for the range of intermediate care services and facilities available so that they can manage the workforce and the budget assigned to various forms of step-up / down care in order to make best use of resources. This is in the early stages of exploration in specific areas where service delivery is likely to benefit from bringing disparate teams together between organisations and under shared management and will be taken forward further in the next phase of work.

9.14 However, we have not yet reached the point of having a joint savings and service development plan for 2018/19 between Councils, CCGs and Trusts. Transformation programmes have not been fully shared between Trusts and commissioning organisations. All organisations are planning improvement and savings programmes for 18/19 and there is therefore an opportunity to give this further focus.

9.15 Joint Performance Measures

9.16 Within the Partnership Agreement a commitment was made to establish a set of performance indicators to help demonstrate increased collaborative working across the Partnership.

9.17 This work has been taken forward and a ‘balanced scorecard’ is being developed. Both Councils have been working on a set of ‘pledges’ or ‘I statements’ that they will use in order to guide and measure their work both at a commissioning and delivery level. This will provide a helpful shared set of indicators to direct and track the impact of our work.

9.18 Joint Budget Management

9.19 The Partnership Agreement set out an ambitious aim of developing a shadow single system control total by September 2017; monthly sharing of budget (and activity data) and to establish system-wide budgets for specific services such as diabetes and MSK to support transformation work.

9.20 We have made progress in bringing investment / dis-investment decisions to the Sponsor Board in order to understand the impact of these changes. There have been, for example, useful conversations about the impact of planned changes in MSK pathways on hospitals and the potential implications arising from investment decisions made by CCGs in CHINs and QISTs.

9.21 Consideration now needs to be given to our level of ambition in terms of financial transparency and shared decision-making. Our service development work is not, in most areas, at the stage where system-wide budgets are required. Between October and December, a piece of work will be undertaken with finance leads to consider the steps we need to take to ensure that we have shared access to service-level budgets on a case-by-case basis where needed and, more strategically, to develop a plan of how want to shape our

financial incentives and practices to support sustainability across the health and care economy.

9.22 Governance

9.23 In order to streamline governance and decision-making between Boroughs, both Haringey and Islington are bringing their integrated care boards together to become a Wellbeing Care Closer to Home group. This will review progress with CHIN / QIST development as well as workstreams and, particularly, services that are jointly commissioned through the Better Care Fund.

9.24 Chairs of the communication and engagement committees, together with management engagement leads, have advised that community engagement should take place on a range of different levels: through engagement at workstream / initiative level; through participation on relevant decision-making committees and through existing forums and engagement networks. An engagement plan is being developed and will be taken to the next Sponsor Board meeting.

10. Contribution to strategic outcomes

10.1 The Wellbeing Partnership contributes towards the strategic outcomes set by both Haringey and Islington's Health and Wellbeing Boards: Ensuring every child has the best start in life; reducing obesity; improving healthy life expectancy; improving mental health and wellbeing and reducing health inequalities. It is expected to contribute towards delivering high quality, efficient services within the resources available.

10.2 Statutory Officers comments

10.3 Legal

Legal

The Wellbeing Partnership Agreement sets out a number of commitments and targets by partners aimed at fostering a collaborative approach in strategic planning and decision making and to improve the health and care economy for residents across Haringey and Islington.

The commitments as they are developed and progressed may require formal partnership agreements between some or all the partners and will need to be managed in accordance with the partner's constitutional and decision making framework.

Overall, the push in the agreement towards more collaborative working is in accordance with health and social care legislations which actively promotes health and social care integrated working and partnership arrangements to improve the health and wellbeing of residents.

The Committee has strategic oversight of the Wellbeing Partnership arrangement.

10.4 Finance

There are no new financial implications from this update report.

We have previously noted that the creation of an Accountable Care Partnership that potentially could involve the budgets for Adults Social Care and Health in LB Haringey, Haringey CCG, LB Islington, Islington CCG and partner healthcare trusts is a major undertaking with both risks and opportunities to organisations. At this stage, we are working to establish the practical steps that would be necessary in order to establish budgets across organisations for particular populations or services and the implications. The Wellbeing Partnership needs to have access to sufficient resources to undertake this work.

10.5 Environmental Implications

10.6 Not applicable at this stage.

10.7 Resident and Equalities Implications

10.8 Not applicable for this report. Equality Analysis will be a vital part of ensuring the programme delivers improvements across our diverse population and does not impact negatively on any specific groups.

11. Use of Appendices

11.1 None.